

Hyperkalemia—Consider the Possibility of a Pseudoabnormality

TO THE EDITOR: We enjoyed the recent medical staff conference on hyperkalemia, but wish to remind readers to consider the possibility of pseudohyperkalemia in the differential diagnosis of the etiology of this condition.¹ Pseudohyperkalemia associated with thrombocytosis is a well-described abnormality which may occur in chronic granulocytic leukemia, polycythemia rubra vera, agnogenic myeloid metaplasia or primary thrombocytosis.² In these cases the platelet count is usually greater than $1,000 \times 10^9$ per liter. The artifact in these conditions appears to involve the release of platelet potassium during coagulation and diagnosis of pseudohyperkalemia can be readily confirmed by determining a plasma potassium level. Recently in a patient with chronic granulocytic leukemia with thrombocytosis a normal electrocardiogram in the face of a serum potassium of 7 mmol per liter was a clue to the existence of pseudohyperkalemia.

In their review, Alvo and Warnock recommended instituting therapy without delay when the serum potassium value is above 6.5 even if the electrocardiographic findings are normal; we would suggest also considering the possibility of pseudohyperkalemia before undertaking therapy in these circumstances.

MALCOLM L. BRIGDEN, MD
ETHEL V. PREECE, RT
Island Medical Laboratories
4489 Viewmont Avenue
Victoria, BC V8Z 5K8

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Another Cause of Diarrhea in AIDS

TO THE EDITOR: Although patients with acquired immunodeficiency syndrome (AIDS) commonly have diarrhea, the incidence of *Mycobacterium avium-intracellulare* as a probable etiologic agent was first described only in 1983.¹ We now present yet another case of diarrhea secondary to this organism in a patient with AIDS.

Report of a Case

A 40-year-old bisexual man, an intravenous drug abuser, presented with a nine-month history of severe watery diarrhea five to ten times per day. He had a history of HbsAg-negative chronic active hepatitis, intermittent oral candidiasis and herpes, as well as shigella, amoeba, rectal gonorrhea, syphilis, rectal fissures and hemorrhoids. His outpatient work-up was negative for gonorrhea, chlamydia, syphilis, bacteria and ova and parasites, including cryptosporidium. Findings on flexible sigmoidoscopy were grossly normal.

On admission, the patient was cachectic, had splenomegaly and a leukocyte count of 2,300 per μ l. A bone marrow biopsy specimen showed prominent collections of epithelioid histiocytes forming noncaseating granulomata. With special stains, multiple collections of acid-fast bacilli were seen. A sigmoid colon biopsy specimen showed a large number of foamy macrophages filling the lamina propria of the mucosa between the glands without distinct granulomata. However, acid-fast and periodic acid-Schiff stains showed many acid-fast organisms packing the cytoplasm of the foamy cells. Both tissues later grew *Mycobacterium avium-intracellulare*. The patient was initially treated with isoniazid and rifampin, but therapy later was changed to a regimen of chlorfazamine and ansomycin. Despite therapy, however, he expired.

Mycobacterium avium-intracellulare should be added to the host of other causes of diarrhea in a patient with AIDS.

HOWARD EDELSTEIN, MD
MICHAEL SILPA, MD
Highland General Hospital
Oakland, CA 94602

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Emergency Room Physicians

TO THE EDITOR: I feel compelled to comment on the article by Sanders and Kobernick concerning the education of internists in emergency medicine.¹ No specialty wants to be any more restricted in its scope of practice than necessary. However, as a pediatrician, I find that internists make some of the worst emergency room physicians because they neither know pediatrics nor recognize their ignorance in that field. The curriculum proposed by Sanders and Kobernick gives only superficial coverage of pediatric emergencies. No mention is made of attempts to teach these physicians to diagnose and treat the more mundane but nonetheless important pediatric problems seen in emergency rooms. To expect a resident whose interest lies with adult medicine to absorb sufficient pediatrics in one to three months of training is unreasonable.

Likewise, I suspect that pediatricians would not be able to learn adult medicine under these circumstances. Training of internists for adult medical emergencies (and pediatricians for pediatric emergencies, and the like) is commendable. To believe that such training would allow internists, pediatricians or general surgeons to function well in a general emergency room is not only a fantasy but a dangerous one.

STEPHEN E. JACOBS, MD
1540 Florida Avenue, Suite 205
Modesto, CA 95350

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